Date: [Date]

To: [Health Insurance Company Name]
Attention: Pharmacy Benefit Manager / Appeals Department
Fax Number: [Fax Number]
Address: [Address, City, State, Zip]

RE: Urgent Step Therapy Override Exception Request

Patient Name: [Patient Name]
Patient Date of Birth: [DOB]
Member ID: [Member ID Number]
Group Number: [Group Number]

To Whom It May Concern,

I am writing to formally request a step therapy override for **[Prescribed Medication Name]**. My patient is currently being treated for **[Diagnosis/Condition]**.

According to your formulary guidelines, the patient is required to first try **[Required Step Therapy Medication(s)]**. However, the required medication(s) are contraindicated for this patient due to a **severe drug-drug interaction**.

Clinical Justification:

- **Current Medication:** The patient is currently taking **[Name of Current Medication]** for **[Other Condition]**.
- **Interaction Severity:** Co-administration of **[Required Step Therapy Medication]** and **[Current Medication]** results in a known severe interaction characterized by **[Describe Interaction, e.g., increased toxicity, metabolic inhibition, serotonin syndrome, QT prolongation]**.
- **Risk:** Requiring the patient to undergo step therapy would pose a significant risk of physical harm or clinical instability.

The prescribed medication, **[Prescribed Medication Name]**, does not carry the same risk of interaction and is the medically necessary choice for this patient's treatment plan.

I have attached [relevant medical records / pharmacological interaction reports] to support this request. Please expedite this review to ensure no interruption in patient care.

Sincerely,

[Physician Name]
[NPI Number]
[Practice Name]

[Phone Number]
[Email Address]